

**West Nile Virus Pages from the**  
**Microbiology Client Services Manual**

**State of Utah Public Health Laboratory**  
**46 North Medical Drive**  
**Salt Lake City, UT 84113-1105**  
**Phone: 801-584-8400 FAX: 801-584-8486**

**Utah Department of Health**

**MICROBIOLOGY CLIENT SERVICES MANUAL**  
**State of Utah Public Health Laboratory**

**GENERAL INSTRUCTIONS**

**CONTACT US:**

**ADDRESS, PHONE, FAX, and WEBSITE**

State of Utah Public Health Laboratory  
46 North Medical Drive  
Salt Lake City, UT 84113-1105  
*Phone: 801-584-8400*  
FAX: 801-584-8486  
Webpage: [HTTP://health.utah.gov/els/microbiology](http://health.utah.gov/els/microbiology)

**KEY PERSONNEL**

Billing

Bob Anderson

Environmental (Water) Microbiology

Sanwat Chaudhuri, Ph.D. -- Section Chief

Microbiology Bureau

Barbara Jepson, MPA, MT(ASCP) -- Bureau Director

Dan Andrews, MS, MT(ASCP) -- Section Chief of Bacteriology,

Food Bacteriology, Mycobacteriology, Parasitology

Jana Coombs, BS, M/SV (ASCP) -- Section Chief of Newborn Screening

Barbara Jepson, MPA, MT(ASCP) – Acting Section Chief of Molecular  
Biology, and Bioterrorism Coordinator

Tom Sharpton, MS, SM(ASCP) -- Section Chief of Immunology, Virology

Technical Services

Chris Peper, MT(ASCP) -- Section Chief

**REPORTING:**

**You must supply your correct Customer ID Code to receive test results.**

Some mail services and couriers are taking a week or more to get your samples to us.

If you are having problems with turn around time for results, check your delivery method.

See individual test for specific reporting criteria and methods.

**REQUISITIONS:**

Blank request forms with your customer ID code are available from Technical Services  
(also see Appendix B for blank forms WITHOUT the customer ID).

**All information must be provided. Incomplete requisitions cannot be processed.**

**SPECIMEN LABELING:** See individual requirements under specific test.

**\*\*\*NOTE: Specimen containers from the State of Utah Public Health Lab have an outdate printed on the label. Do not collect any sample in an outdated container.**

**Call Technical Services at 801-584-8204 for a new container.**

We do not supply blood collection tubes.

**MICROBIOLOGY CLIENT SERVICES MANUAL**  
**State of Utah Public Health Laboratory**

**LAB TEST – Immunology Section**

<b>TEST</b>	West Nile Virus (Human) IgM ELISA
<b>METHOD</b>	Enzyme Linked Immunosorbent Assay (ELISA)
<b>AVAILABLE</b>	Prior to submitting specimen, contact UDOH Epidemiology at (801)538-6191.
<b>PATIENT PREP</b>	Symptoms, vaccinations, and travel history
<b>SPECIMEN</b>	Serum or cerebrospinal fluid
<b>COLLECT IN</b>	N/A
<b>PROCESSING</b>	Serum: refrigerate (freeze if transport delayed) CSF: refrigerate if transport delayed
<b>TRANSPORT</b>	Serum: refrigerate during transport (freeze if transport delayed) CSF: refrigerate if transport delayed
<b>TIME CRITICAL</b>	Within 12 hrs of collection
<b>LABEL</b>	Patient's full name or unique ID number, date of collection, and date of onset of symptoms
<b>REQUISITION</b>	Immunology/Serology Test Request Form (see form in Appendix B)
<b>TEST COMPLETE</b>	72 hrs after receipt in our lab
<b>RESULTS</b>	WNV antibody detected by ELISA; WNV not detected by ELISA
<b>REPORTED</b>	Phone, fax, or email, as established with provider
<b>NOTE</b>	If initial serum specimen was collected within 9 days of onset of symptoms, a convalescent serum will be requested for IgM negative tests.
<b>CONTACT</b>	Immunology Section

**MICROBIOLOGY CLIENT SERVICES MANUAL**

**State of Utah Public Health Laboratory**

**LAB TEST – Molecular Biology Section**

<b>TEST</b>	West Nile Virus, St. Louis Encephalitis Virus, or Western Equine Encephalitis Virus
<b>METHOD</b>	Polymerase Chain Reaction (PCR)
<b>AVAILABLE</b>	Contact Michelle Korth at (801)538-6191 or Kris Fehlberg at (801) 538-4767 for submitting avian oral swabs and dead bird reports.
<b>PATIENT PREP</b>	N/A
<b>SPECIMEN</b>	Mosquitoes = 10-50 insects, available Mosquito Abatement Districts. Avian oral swabs. Bird or horse tissues = 1 cubic centimeter brain, spleen, or heart .
<b>COLLECT IN</b>	Mosquitoes = tubes from Mosquito Abatement District. Swabs = Ziploc bags; outer bag must be clean. Tissue = sterile, leak proof container.
<b>PROCESSING</b>	Keep mosquitoes and tissue samples at 2 - 8 degrees C. Avian oral swabs at ambient temperature.
<b>TRANSPORT</b>	On wet ice or in mailer
<b>TIME CRITICAL</b>	Within 48 hrs of collection
<b>LABEL</b>	Location and date of collection. Species of source animal.
<b>REQUISITION</b>	Molecular Biology Test Request Form (see form in Appendix B)
<b>TEST COMPLETE</b>	48 hrs after receipt in our lab
<b>RESULTS</b>	Virus detected by PCR; virus not detected by PCR
<b>REPORTED</b>	Mail, e-mail, or fax, as established with provider
<b>NOTE</b>	N/A
<b>CONTACT</b>	(801)584-8449: Kim Christensen, or (801)584-8595: Barbara Jepson.

**IMMUNOLOGY/SEROLOGY TEST REQUEST FORM**

**FOR LABORATORY USE ONLY**  
LAB#:

**STATE OF UTAH PUBLIC HEALTH LABORATORY**  
46 NORTH MEDICAL DRIVE  
SALT LAKE CITY, UTAH 84113-1105  
TELEPHONE: (801) 584-8400 FAX: (801) 584-8486

DATE STAMP:

**TESTING WILL NOT BE PERFORMED UNLESS SLIP IS COMPLETELY FILLED OUT. PLEASE PRINT CLEARLY FOR ACCURACY.**

**PATIENT INFORMATION:**

Patient Name (Last, First): \_\_\_\_\_

Patient ID #: \_\_\_\_\_ DATE OF BIRTH (mm/dd/yy) \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: \_\_\_\_\_  
M F

**PROVIDER INFORMATION:**

Provider Code: \_\_\_\_\_ Physician: \_\_\_\_\_  
Provider Phone: \_\_\_\_\_  
Provider Email: \_\_\_\_\_  
Secure Fax #: \_\_\_\_\_

**SPECIMEN COLLECTION DATE**

(MM/DD/YY)

/ /

**Syphilis Serology**

- RPR (1, 2)
  - 1st Specimen (1)       2nd Specimen(2)
- Previous Positive RPR (3)
- Previous Positive FTA (11)
- Contact (4)
- Prenatal (8)
- FTA-ABS (2, 4)

**STATE OF ORIGIN OF PATIENT/SAMPLE**

\_\_\_\_\_

**Miscellaneous Serology:**

- HBsAg (antigen) (5)
- HbsAb (antibody) (13, 14)
- HCVAbs (antibody) (18)
- Hantavirus (Sin Nombre) (55)
- SARS (Total Antibody) (60)
- St. Louis Encephalitis Virus (IgM)
- West Nile Virus (IgM)
- Other\*

Specific Agent Suspected: \_\_\_\_\_

**\*(Please call the Immunology Laboratory at 584-8400 for special instruction and/or availability before ordering.)**

Date of Onset (mm/dd/yy): \_\_\_\_/\_\_\_\_/\_\_\_\_

**ADDITIONAL INFORMATION**

(List pertinent information including presumptive ID)

**Specimen Information:**

- Acute serum  
drawn on (mm/dd/yy): \_\_\_\_/\_\_\_\_/\_\_\_\_
- Convalescent serum  
drawn on (mm/dd/yy): \_\_\_\_/\_\_\_\_/\_\_\_\_


<b>MOLECULAR BIOLOGY TEST REQUEST FORM</b>	<b>FOR LABORATORY USE ONLY</b> LAB#:
<b>STATE OF UTAH PUBLIC HEALTH LABORATORY</b> 46 NORTH MEDICAL DRIVE SALT LAKE CITY, UTAH 84113-1105 TELEPHONE: (801) 584-8400 FAX: (801) 584-8486	DATE STAMP:

**TESTING WILL NOT BE PERFORMED UNLESS SLIP IS COMPLETELY FILLED OUT. PLEASE PRINT CLEARLY FOR ACCURACY.**

<b>PATIENT INFORMATION:</b>			
Patient Name (Last, First): _____			
Patient ID #:	DATE OF BIRTH (mm/dd/yy) ____/____/____	AGE: _____	SEX: M            F

<b>PROVIDER INFORMATION:</b>	Physician: _____	<b>SPECIMEN COLLECTION DATE</b>
Provider Code:	Provider Phone: _____	(MM/DD/YY)
	Provider Email: _____	/            /
	Secure Fax #: _____	

<b>SPECIMEN SOURCE/SITE:</b>	<b>TEST ORDERED:</b>
<input type="checkbox"/> Serum <input type="checkbox"/> CSF <input type="checkbox"/> Nasopharyngeal swab <input type="checkbox"/> Aspirate (specify): _____ <input type="checkbox"/> Bronchial/Tracheal Wash <input type="checkbox"/> Tissue (specify): _____ <input type="checkbox"/> Scab <input type="checkbox"/> Body fluid (specify): _____ <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Stool <input type="checkbox"/> Plasma <input type="checkbox"/> Isolate (source): _____	<input type="checkbox"/> <i>Bordetella pertussis</i> PCR <input type="checkbox"/> West Nile Virus PCR <input type="checkbox"/> St. Louis Encephalitis Virus PCR <input type="checkbox"/> Western Equine Encephalitis PCR <input type="checkbox"/> SARS PCR <input type="checkbox"/> ORSA PFGE <input type="checkbox"/> Varicella zoster virus PCR <input type="checkbox"/> Vaccinia virus PCR <input type="checkbox"/> Other (specify): _____

<b>RESULTS</b>	<b>STATE OF ORIGIN OF PATIENT/SAMPLE</b> _____
<hr/> <hr/> <hr/>	<b>ADDITIONAL INFORMATION</b> (List pertinent information including presumptive ID)
	<hr/>